Gwinnett Surgical Associates

770-962-9977

Your Name: ____

Preferred Name: __________________________ **Primary Language**: ________________________

Date of Birth: _____________________________ **SSN**: ___________________________________

Preferred Pharmacy, Address, Phone #, & City: ____

Race: ☐ American Ind./Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Other

☐ Nat Hawaiian/Pacific Islander ☐ Declined **Marital Status:** S M D W

Ethnicity: (*MUST COMPLETE*) ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Declined

Address: ____ **Apt#** ____________

City: ______________________ **State**: ______________________ **Zip Code**: ________________

Home # ____________________ **Work #** _____________________ **Cell #** ____________________

Email: ___________________________________ **Employer:** ______________________________

Preferred Communication for Appointment Reminders: ☐ Email ☐ Phone ☐ Text ☐ Other______

Emergency Contact: ______________ **Relationship:** ___________ **Phone #** _________________

Is your Insurance through (please check all that apply): ☐ My employer ☐ Private ☐ Spouse ☐ Parent

Policy Holder Employer: _______________________ **ID#** ______________________________________

Insurance Co. Name: ______________________ **Group Name/#** _______________________________

Insurance Company Address: ____

Policy Holders Name: ____

Policy Holders DOB (*MUST HAVE*): ________________ **Policy Holders SSN#** _______________________

Secondary Insurance Name: _________________ **ID#** _____________ **Group Name/ #**_____________

Insurance Company Address: ____

Policy Holders Name: ____

Policy Holders DOB (*MUST HAVE*): ________________ **Policy Holders SSN#** _______________________

Is this workmans comp ☐ Yes ☐ No **If yes, Contact Name:** ________________ **Phone** _____________

Date and Nature of Injury: ____

It is the policy of this office to pay for services in full when rendered. We will file your claim and you will be expected to pay only what the insurance does not pay. You must have your current insurance card at time of service or you will be expected to pay in full. Return check fee is $30. A no show fee of $25 for office visit will be charged. A $100 for procedures in office, hospital, or surgery center will be billed if notification of cancellation of appointment is not received at least 24 hours prior to scheduled procedure. Insurance is not a guarantee of payment. It is your responsibility to confirm your benefits. In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein incurred. If this account is placed with a collection agency, the undersigned parties agree to pay all fees for cost of collections.

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of this claim.

PATIENT OR GUARDIAN SIGNATURE:_____________________________________ DATE:___________

HIPPA PRIVACY RULE: Please list the parties that you authorize Gwinnett Surgical Associates to disclose you protected health information (PHI). **<u>MUST BE FILLED OUT BY PATIENT only</u>**

Name:____ Relationship:___________________________

Name:____ Relationship:___________________________

I HAVE RECEIVED/READ A COPY OF GWINNETT SURGICAL ASSOCIATES NOTICE OF PRIVACY PRACTICES.

*Patients Initials*_____________

Referring Physician_______________________________ Phone #________________________________

Reason for Visit Today:____

Drug Allergies:____

Medications and Dosage you are taking:____

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____

Do You Smoke☐ Yes ☐ No How Long:______ How many per day:______ Alcohol Intake: ☐yes ☐no

Respiratory: Doctor's Name:____

Please check all that apply: ☐ Sleep Apnea ☐ COPD ☐ Asthma ☐ Bronchitis ☐ Pulmonary Embolus
☐ Lung Cancer ☐ Tuberculosis ☐ Pneumonia ☐ Shortness of Breath/Cough ☐ Cough up Blood

Cardiovascular: Doctor's Name: ____

☐ Heart attack: When _____ ☐ Coronary Artery Disease ☐ Heart Failure / CHF ☐ Abnormal EKG
☐ Arrhythmia ☐ Pacemaker/defibrillator ☐ Angioplasty/Stent ☐ Heart Valve ☐ Angina/chest pain
☐ Stroke ☐ Hypertension ☐ High Cholesterol ☐ Blood Clot/DVT ☐ Leg Swelling ☐ Pain with walking
☐ Non- healing wounds ☐ Varicose Veins

GI: Doctor's Name: ____

☐ GERD ☐ Weight Loss ☐ Blood in Stool ☐ Change in Bowel Habits ☐ Constipation

Endocrine: Doctor's Name: ____

☐ Diabetes: Diet / Pill / Insulin / Pump ☐ Thyroid Disease: Hypo / Hyper ☐ Abnormal Calcium Level

PRIOR SURGERY, ILLNESS, OR INJURY AND ANY COMPLICATIONS:_______________________________

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